The bacterial origin of gout is discussed. Trautner regards Bacillus coli communis as the cause of the disease. Others have supported the bacterial theory. Regarding the subject Hall says: "We cannot yet suppose a specific organism for gout, and the general metabolism plays a greater part in regard to the action of accidental or exceptonal intestinal toxins than is generally acknowledged. At the same time, it must be conceded that hereditary deficiencies in digestive faculties, or idiosyncrasies of metabolic functions, may permit the formation of exceptional toxins, or decrease the resistance to products of the ordinary intestinal bacteria."

Much work has been done on the relationship of glycocol to the etiology of gout. Hall, himself, finds it present in the urine in 70 per cent. of the cases, but states that there is no present proof that it is a causative factor. Shearer has suggested that an excessive quantity of carbonic acid in the arterial blood is a condition that leads to gout, and states that exercise, consequently, has a beneficial effect upon those subject to the disease because it increases the exhalation of carbonic acid.

Hall claims that hepatic insufficiency accounts for many of the symptoms of gout. Hepatic stimulants give the best results. He does not state what ones he uses. The accurate adjustment of food to the capacities of the intestinal mucosa and the liver is one of the best forms of treatment. The purins in the food and the purins in the urine are taken as the indicators.

Bacteriology of a "Common Cold."—BENHAM (*Brit. Med. Jour.*, 1906, ii, 1023) made a bacteriological study of the nasal secretions in twenty-one cases of mild "common cold" occurring in the vicinity of Brighton, England. There was no influenza epidemic prevailing. The clinical symptoms were usually sore throat, sneezing, malaise, headache, more or less nasal discharge, and slight fever. Most of the patients were able to go about. The previous work done on the bacteriology of the nasal discharge in normal persons and in persons with colds is reviewed. Of the 21 cases diphtheroid organisms were found in 20 (95 per cent.) of the cases. In 5 these bacilli were isolated in pure culture. Cocci negative to Gram's stain were found in 10 cases (48 per cent.) and isolated in pure culture in 2. Other cocci positive to Gram's stain were seen in 14 cases (67 per cent.). Some were undoubtedly pneumococci, but they were few in all cases and not isolated in any of them. Pfeiffer's influenza bacillus was found in only 2 instances, but was not isolated in pure culture.

It will be seen that a diphtheroid organism was almost a constant accompaniment of the colds. The cultural and biochemical characteristics of the organism are described in detail. Microscopically it is a short bacillus which tapers to rounded ends, In early cultures it is so short as to resemble an oval coccus. The average length in a three-day-culture is 1.5 microns and the breadth 0.3 to 0.4 micron. By the third day a characteristic appearance develops. The protoplasm at the ends of the bacillus is deeply stained, leaving an unstained band or septum across the middle of the bacillus. With a good illumination the outline of the bacillus can be clearly seen, especially in specimens counterstained with carbol-fuchsin. Benham thinks the organism has frequently been mistaken by previous observers for a diplococcus or diplobacillus. Cultural and microscopic characteristics are cited that distinguish the organism from the true diphtheria bacillus.

The pathogenicity of the organism in animals was not definitely determined. Benham has suggested the tentative name of Bacillus septus for the bacillus. He thinks that it is probably identical with the organism isolated by Cantley and called Bacillus coryzæ segmentosus. He believes that the organism is responsible more for the sore throat, headache, malaise, and muscular pains than for the coryza. The coryza, when present, was probably due to the micrococci found and these he stated had the characteristics of the Micrococcus catarrhalis of Pfeiffer. The investigation favors the view that "common colds" are in all probability due to bacterial infection.

Xanthoma Tuberosum Diabeticorum. ABRAHAMS (*The Post-Graduate,* 1906, xxi, 533) reports an instance of this form of xanthoma of eight years standing in a male diabetic, fifty years of age. It began as a small, painful nodule at the nape of the neck near the border of the hair. After the patient first picked it off with the finger nail, it returned and steadily grew. One year after its appearance diabetic symptoms became marked. The mass gradually grew until it reached an inch by an inch and a half in size. It was made up of a series of nodules or tubercules of hazel-nut size—round, smooth, and lobulated. The upper border of the growth was red, the lower border pale.

The patient eventually began to experience difficulty in swallowing. He was unable to swallow any solid food whatever. The passage of a bougie revealed a stricture of the œsophagus near the cardiac orifice of the stomach. Two well-known clinicians, overlooking the xanthoma on the neck, made a diagnosis of carcinoma of the œsophagus. With proper diet and medicines the patient became aglycosuric, the tumor steadily diminished in size, and the dysphagia gradually disappeared, so that he could eat chopped meat, potatoes, and crackers. Xanthomata are well known to attack the œsophagus, heart, and other internal organs in diabetes, and Abrahams thinks that there is little doubt that the stricture of the œsophagus in this case was due to a local xanthomatous tumor. It is well known that xanthomata in diabetes disappear with the disappearance of the sugar in the urine, to return again with the reappearance of glycosuria.

On the Presence of Kernig's Sign in Zona.—BELBEZE (*Archives Générales de Médecine,* 1906, lxxxiii, 520) states that in the last four years he has observed nineteen cases of herpes zoster or zona, and has examined each case for the presence or absence of Kernig's sign. In only two instances was it present. Both cases were in women, one sixty and the other sixty-five years of age. In both instances also the eruption was along the course of one or more branches of the lumbar nerves.

Complications of Acute Pneumonia.—HENRY JACKSON (*Boston Med. and Surg. Jour.,* May 31, 1906, p. 620) has analyzed the various complications occurring among 1320 cases of acute lobar pneumonia treated at the Boston City Hospital. The complications directly connected with the lung were as follows: Empyema, 22 cases; lung abscess, 4 cases; lung gangrene, 3 cases; pleurisy with large effusion, 23 cases; unresolved pneumonia, 5 cases.